Filing at a Glance

Company:	National Western Life Insurance Company
Product Name:	01-9063-12 APPLICATION FOR INDIVIDUAL LIFE INSURANCE
State:	Arkansas
TOI:	L09I Individual Life - Flexible Premium Adjustable Life
Sub-TOI:	L09I.001 Single Life
Filing Type:	Form
Date Submitted:	01/04/2013
SERFF Tr Num:	NAWS-128834232
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	01-9063-12 APPLICATION FOR INDIVIDUAL LIFE INSURANCE
Implementation Date Requested:	On Approval
Author(s):	Stephanie Foskitt, Kitty Kennedy
Reviewer(s):	Linda Bird (primary)
Disposition Date:	01/10/2013
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: Arkansas **Filing Company:** National Western Life Insurance Company
TOI/Sub-TOI: L09I Individual Life - Flexible Premium Adjustable Life/L09I.001 Single Life
Product Name: 01-9063-12 APPLICATION FOR INDIVIDUAL LIFE INSURANCE
Project Name/Number: 01-9063-12 APPLICATION FOR INDIVIDUAL LIFE INSURANCE/01-9063-12 APPLICATION FOR INDIVIDUAL LIFE INSURANCE

General Information

Project Name: 01-9063-12 APPLICATION FOR INDIVIDUAL LIFE INSURANCE
Status of Filing in Domicile: Authorized

Project Number: 01-9063-12 APPLICATION FOR INDIVIDUAL LIFE INSURANCE
Date Approved in Domicile:

Requested Filing Mode: Review & Approval
Domicile Status Comments: This application is deemed exempt by our state of domicile, Colorado.

Explanation for Combination/Other:
Market Type: Individual

Submission Type: New Submission
Individual Market Type:

Overall Rate Impact:
Filing Status Changed: 01/10/2013

State Status Changed: 01/10/2013

Deemer Date:
Created By: Stephanie Foskitt

Submitted By: Stephanie Foskitt
Corresponding Filing Tracking Number:

Filing Description:

RE: Application for Individual Life Insurance, 01-9063-12
National Western Life Insurance Company, NAIC 66850, FEIN 84-0467208

To whom it may concern:

Please find attached the referenced life insurance application submitted for review and approval. 01-9063-12 is nearly identical to a previously approved application form 01-9063-10 approved for use on March 25, 2010 under SERFF tracking number NAWS-126543268. Following is a list of the differences:

• Addition of the Return of Premium Rider option to the front of the application.

• Modification of question 3 in Section VIII:
o FROM: Do you use a walker, wheelchair, motorized scooter or any medical appliance such as oxygen, respirator, or dialysis machine, or have a defibrillator implanted?

o TO: Do you use any medical appliance such as oxygen, respirator, or dialysis machine, or have a defibrillator implanted?

• Removal of question 6c in Section VIII

• Addition of text under question 16 in Section IX as follows: “Details to yes answers in Section IX”

• Addition of question 17 in Section IX as follows: “Physician’s Name, Address, and Phone Number”

• Addition of a sentence in the authorization section as follows: “Is not currently taking and is not under the influence of any medications or drugs that would affect the ability to fully understand and to fully and accurately complete this application.”

• Addition of a sentence to the bottom of the Temporary Receipt information as follows: “Leave receipt with applicant if money is collected. If no funds are collected indicate none and submit this page along with application.”

Thank you for your time and consideration in this matter. If you have any questions or need any additional information, please

feel free to contact me at (512) 719-1563 or by email at SFoskitt@NationalWesternLife.com.

Sincerely,
Stephanie Foskitt
Contract Compliance Analyst

We reserve the right to change the format of this form without changing any of the language. Printing standards will never be less than those required by your state.

Company and Contact

Filing Contact Information

Stephanie Foskitt, Contract Compliance Analyst
National Western Life Insurance Company
850 East Anderson Lane
Austin, TX 78752

SFoskitt@NationalWesternLife.com
512-719-1563 [Phone]
512-719-8522 [FAX]

Filing Company Information

National Western Life Insurance Company
850 East Anderson Lane
Austin, TX 78752-1602
(512) 836-1010 ext. [Phone]

CoCode: 66850
Group Code:
Group Name:
FEIN Number: 84-0467208

State of Domicile: Colorado
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	$50 per application filed separately from the base policy x 1 application = $50 total
Per Company:	No

Company	Amount	Date Processed	Transaction #
National Western Life Insurance Company	$50.00	01/04/2013	66252010

SERFF Tracking #:	*NAWS-128834232*	***State Tracking #:***		***Company Tracking #:***	*01-9063-12 APPLICATION FOR INDIVIDUAL LI...*

State:	*Arkansas*	***Filing Company:***	*National Western Life Insurance Company*
TOI/Sub-TOI:	*L09I Individual Life - Flexible Premium Adjustable Life/L09I.001 Single Life*		
Product Name:	*01-9063-12 APPLICATION FOR INDIVIDUAL LIFE INSURANCE*		
Project Name/Number:	*01-9063-12 APPLICATION FOR INDIVIDUAL LIFE INSURANCE/01-9063-12 APPLICATION FOR INDIVIDUAL LIFE INSURANCE*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/10/2013	01/10/2013

SERFF Tracking #:	*NAWS-128834232*	***State Tracking #:***		***Company Tracking #:***	*01-9063-12 APPLICATION FOR INDIVIDUAL LI...*

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Project Name/Number:	*01-9063-12 APPLICATION FOR INDIVIDUAL LIFE INSURANCE/01-9063-12 APPLICATION FOR INDIVIDUAL LIFE INSURANCE*		

Disposition

Disposition Date: 01/10/2013
Implementation Date:
Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document	COVER LETTER		Yes
Supporting Document	STATEMENT OF VARIABILITY		Yes
Form	Application for Individual Life Insurance		Yes

SERFF Tracking #:	*NAWS-128834232*	***State Tracking #:***		***Company Tracking #:***	*01-9063-12 APPLICATION FOR INDIVIDUAL LI...*

State:	*Arkansas*	***Filing Company:***	*National Western Life Insurance Company*
TOI/Sub-TOI:	*L09I Individual Life - Flexible Premium Adjustable Life/L09I.001 Single Life*		
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Project Name/Number:	*01-9063-12 APPLICATION FOR INDIVIDUAL LIFE INSURANCE/01-9063-12 APPLICATION FOR INDIVIDUAL LIFE INSURANCE*		

Form Schedule

Lead Form Number: 01-9063-12

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Application for Individual Life Insurance	01-9063-12	AEF	Initial		53.000	01-9063-12.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

NATIONAL WESTERN LIFE INSURANCE COMPANY®

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

850 East Anderson Lane • Austin, Texas 78752-1602

I. PRIMARY INSURED (Please Print Clearly Using Black Ink)

Name of Proposed Insured (First, Middle, Last) _____ Date of Birth (mm/dd/yyyy) _____ Age _____ Place of Birth (State and Country) _____

❒ Male ❒ Female Marital Status ❒ Married ❒ Single ❒ Widowed ❒ Divorced ❒ Tobacco Use ❒ Tobacco Free

Home Address (number and street) _____ City _____ State _____ Zip _____

Social Security Number or Tax ID _____ Drivers License Number and State _____ Home Phone Number _____ Best time and place to call ❒ Home_____ ❒AM ❒PM ❒ Work _____ ❒AM ❒PM

Citizenship ❒ U.S. Citizen ❒ Foreign National

If Non US Citizen: Type of Visa_____ Exp date _____ Country of Citizenship _____

Current Employer _____ Occupation and Duties _____ Work Phone Number _____

Employer Address (number and street) _____ City _____ State _____ Zip _____

II. COVERAGE APPLIED FOR

Plan of Insurance (Name of Product) _____ **Face Amount** $ _____

Riders: ❒ Accelerated Benefit Rider (Not available in all states) ❒ Return of Premium Rider (Not available in all states)

Riders are only available for single-premium

III. PREMIUMS

Single Premium $ _____

Modal Premium: ❒ 5 pay $ _____ to be paid: ❒ Annual ❒ Semi-annual ❒ Quarterly ❒ Monthly
❒ 10 pay

Method: ❒ Direct Billing ❒ Bank Draft ❒ Other _____

Amount collected with application: $ _____

Source of Premium: ❒ Salary ❒ Savings ❒ Investments ❒ 1035 Exchange ❒ Loan (premium financing) ❒ Other (specify) _____

IV. OWNERSHIP INFORMATION (Complete only if Owner is other than the Proposed Insured)

Owner / Applicant / Trust Name _____ Date of Birth (mm/dd/yyyy) _____ SSN / TIN _____

Phone Number _____ Relationship to Proposed Insured _____

Address (number and street) _____ City _____ State _____ Zip Code _____

If the owner is a trust, please submit the Trust Information Form.

V. BENEFICIARY INFORMATION (If percentages are not given, the shares will be divided equally)

Primary Beneficiaries

Full Name	Relationship	% Share
1.		
2.		
3.		

Contingent Beneficiaries

Full Name	Relationship	% Share
1.		
2.		
3.		

VI. OTHER COVERAGE AND REPLACEMENT

1. Does the Proposed Insured have any existing life insurance or annuity policies with this company or any other company? (If yes provide details in #5) ❒ Yes ❒ No
2. Is this policy intended to replace any existing life insurance or annuity with this company or any other? ❒ Yes ❒ No (If yes, please submit appropriate state replacement forms and provide company name and details in #5)
3. Is the Proposed Owner or Proposed Insured considering using funds from an existing policy or contract to pay premiums on the Policy being applied for? (If Yes, complete the appropriate state replacement forms and provide company name and details in #5) ❒ Yes ❒ No

4. Company	Policy Number	Type of Coverage	Amt of Coverage	To be Replaced	1035 Exchange
_____	_____	_____	_____	❒ Yes ❒ No	❒ Yes ❒ No
_____	_____	_____	_____	❒ Yes ❒ No	❒ Yes ❒ No
_____	_____	_____	_____	❒ Yes ❒ No	❒ Yes ❒ No
_____	_____	_____	_____	❒ Yes ❒ No	❒ Yes ❒ No

VII. HEIGHT AND WEIGHT

What is your height? _____ ft _____ in: What is your weight? _____Lbs

VIII. MEDICAL HISTORY QUESTIONS (If any question in Section VIII is answered yes, no coverage can be issued.)

1. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ❒ Yes ❒ No
2. Do you have any impairment, whether physical or mental, for which you need or receive assistance or supervision in performing normal activities of daily living such as bathing, dressing, eating, toileting, transferring or taking medications? ❒ Yes ❒ No
3. Do you use any medical appliance such as oxygen, respirator, or dialysis machine, or have a defibrillator implanted? ❒ Yes ❒ No
4. Have you had or been advised by a member of the medical profession to have, an organ transplant, or have you been medically diagnosed as having a terminal illness or life expectancy of 12 months or less? ❒ Yes ❒ No
5. Are you currently hospitalized, confined to a bed or nursing facility, residing in an assisted living facility or receiving hospice care? ❒ Yes ❒ No
6. Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder such as:
   a. Congestive heart failure, cardiomyopathy, cirrhosis of the liver, liver failure, kidney (renal) failure, end stage kidney disease, chronic kidney disease or renal insufficiency? ❒ Yes ❒ No
   b. Alzheimer's disease, dementia, memory loss, mental incapacity, schizophrenia, manic depression, bipolar disorder, brain disease, Lou Gehrig's disease (ALS), Huntington's disease, muscular dystrophy, cystic fibrosis, multiple sclerosis or multiple myeloma? ❒ Yes ❒ No
7. Have you:
   a. Been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for diabetes prior to age 20? ❒ Yes ❒ No
   b. Taken insulin prior to age 40? ❒ Yes ❒ No
   c. Ever been treated for insulin shock or diabetic coma? ❒ Yes ❒ No
   d. Been hospitalized two or more times for any diabetic complications within the last 2 years? ❒ Yes ❒ No
8. Within the past 3 years have you been diagnosed by a member of the medical profession with leukemia, lymphoma, melanoma or any internal cancer, or received chemotherapy, radiation or had surgery for any cancer (other than basal or squamous cell cancer of the skin)? ❒ Yes ❒ No
9. Other than basal cell or squamous cell cancer of the skin, have you ever had more than one occurrence of any cancer, a recurrence of any cancer, or an amputation caused by cancer or any other disease, or are you currently being treated for cancer? ❒ Yes ❒ No

Proposed Insured _____

VIII. MEDICAL HISTORY QUESTIONS CONTINUED (If any question in Section VIII is answered yes, no coverage can be issued.)

10. Within the past 2 years have you:
    a. Been diagnosed or treated by a member of the medical profession for, been hospitalized for, taken or been prescribed medication for: Chronic Obstructive Pulmonary or Lung disease (COPD/COLD), emphysema, chronic bronchitis, respiratory failure, chronic hepatitis, liver disease, angina, stroke, transient ischemic attack (TIA), Hodgkin's disease, cerebral palsy, Parkinson's disease, grand mal epilepsy, systemic lupus (SLE) disease, or do you have paralysis of 2 or more extremities? ..... ❒ Yes ❒ No
    b. Been diagnosed or treated by a member of the medical profession for, or been hospitalized for: Heart disease, heart attack, uncontrolled high blood pressure, heart or circulatory surgery, including coronary artery bypass, angioplasty, cardiac or vascular stent placement, pacemaker or pacemaker replacement, heart valve replacement, abdominal aortic aneurysm, or any procedure to improve the circulation to the heart, brain or extremities? ..... ❒ Yes ❒ No
    c. Been confined three or more times to a hospital, nursing facility, convalescent care facility, assisted living facility, or mental care facility? ..... ❒ Yes ❒ No
    d. Been declined for life, health or long term care insurance? ..... ❒ Yes ❒ No
11. Within the past 5 years have you:
    a. Been convicted of a felony or are you currently incarcerated, on parole, or probation? ..... ❒ Yes ❒ No
    b. Been treated for or been advised to have treatment for alcohol or drug use, or attempted suicide? ..... ❒ Yes ❒ No
12. Within the last 3 years have you been convicted of operating a vehicle while intoxicated, impaired or under the influence or for reckless driving? ..... ❒ Yes ❒ No

IX. ADDITIONAL INFORMATION

13. Are you taking any medication for any impairment or disease listed in section VIII? ..... ❒ Yes ❒ No
14. In the last 12 months, have you used any tobacco or nicotine products, such as cigarettes, pipes or cigars, snuff, chewing tobacco, or a nicotine delivery device such as a patch, gum or lozenge? ..... ❒ Yes ❒ No
15. Have you applied for life insurance with any other insurance companies in the last 2 years? ..... ❒ Yes ❒ No
16. Do you believe that this life insurance policy is appropriate for your financial situation based on your income, net worth, available funds and retirement considerations? ..... ❒ Yes ❒ No

    Details to yes answers in Section IX _____

    _____

    _____

17. Physician's Name, Address, and Phone Number _____

Each of the undersigned: Declares that all answers in this application are true and complete to the best of their knowledge and belief, and understands that: (a) all statements and answers in this application will be relied upon by the Company to determine insurability and to issue the policy; (b) no information will be considered given to the Company unless it is stated in the application; (c) the agent does not have the Company's authorization to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions in the application, policy or receipt, as applicable; and (d) a material misrepresentation may void the policy during the contestable period. This policy will take effect when: (1) the application is approved at National Western's Office in Austin, Texas; (2) National Western delivers the policy; (3) the initial premium has been paid; and (4) each of the prior three conditions is satisfied while the proposed insureds are alive and their health and insurability are as described herein.

Proposed Insured: Is not currently taking and is not under the influence of any medications or drugs that would affect the ability to fully understand and to fully and accurately complete this application. Authorizes any licensed physician, medical practitioner, hospital, other health care provider, insurance company or MIB, or other organization or person to give any information about me or my mental or physical health to the Company and/or its authorized agents to determine my eligibility for life insurance coverage. The Company may disclose such information to its reinsurers and MIB. National Western or its reinsurers may also release such information to other life or health insurance companies to whom an application for insurance or to whom a claim for benefits is submitted. This authorization also applies to any member of my family proposed for coverage in the application and is valid for 2 years after the date shown below. A photocopy of this form is as valid as the original. I may have a copy of this form upon request.

Each of the undersigned acknowledges receipt of the Notice under the Fair Credit Reporting Act (Consumer Report Notice), MIB Disclosure Notice, and Notice of Information Practices (if applicable).

FRAUD WARNING: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

Signed at _____ Date_____
City and State

_____
Signature of Proposed Insured (parent if age 17 or less)

_____
Signature of Owner if other than Proposed Insured
(If a Trust, signature of trustee)
(If business or corporation, officer, other than Proposed insured, and Title)

_____
Agent Name (please print) License No.

_____
Signature of Agent

AGENT REPORT

1. How long have you known the Proposed Insured?_____ Are you related? ❒ Yes ❒ No If yes, How? _____
2. Did you personally see the Proposed Insured(s) and complete the application in his and/or her presence? ..... ❒ Yes ❒ No
   If No, please explain: _____
3. Are you aware of any information about any of the Proposed Insured(s) that might affect his/her insurability? ..... ❒ Yes ❒ No
   If Yes, give details: _____
4. Will the policy applied for replace or change any existing life insurance or annuity? ..... ❒ Yes ❒ No
5. Do you have any knowledge or reason to believe:
   a. that the Proposed Insured or Owner is considering assigning or transferring any rights or interest in this policy to an unrelated third party such as a Life Settlement company, Viatical, Investor, trust, bank, lending institution or other third party? ..... ❒ Yes ❒ No
   b. that any of the initial or future premiums will be borrowed, loaned or otherwise financed? ..... ❒ Yes ❒ No
   c. that the Proposed Insured or Owner has taken or been offered any incentive, financial or other, or been offered free insurance as an inducement to purchase this policy? ..... ❒ Yes ❒ No

I certify that:
a. the insurance being applied for is suitable for the Proposed Insured's needs and financial objectives
b. the consumer notices were delivered to the Proposed Insured or Owner;
c. all questions on the application were asked of each Proposed Insured, and the answers were recorded as given, prior to the application being signed;
d. the temporary insurance agreement was explained fully and (if applicable), the receipt was given.
e. the answers given in this application and Agent's Report are complete and accurate to the best of my knowledge and belief
f. the Proposed Insured and Owner appeared to me to be lucid and to fully understand all of the questions on this application.

Date _____ Agent Signature _____ Print Agent Name _____

Licensed agent(s) to receive commissions (please print)

Name of Agent	Agent No.	Percent of commission	Agent phone #	Agent Email address
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

TEMPORARY INSURANCE AGREEMENT & RECEIPT*

This agreement shall be void if altered or modified. • Premium checks must be made payable to National Western Life.

Proposed Insured _____ Amount Paid $ _____ Application Date_____

Subject to all terms and conditions of the insurance policy applied for in this application, this Temporary Insurance Agreement & Receipt (TIA) provides Temporary Insurance in the amount of the lesser of: (a) the amount of insurance applied for; or (b) $50,000 on each proposed insured; or (c) $250,000 in the aggregate for all insureds listed on the application. This Temporary Insurance will take effect on the effective date and end as defined below.

I have read this Temporary Insurance Agreement & Receipt and it has been explained to me by the agent. I understand and agree to all conditions and limitations. Proposed owner's signature _____Date _____

I explained and witnessed the signing of this Agreement.

01-9063-12 Receipt Agent's signature _____Date _____

Temporary Insurance will take effect on the date that the following four requirements are met: (1) the application is fully completed, including any amendments required by National Western; (2) the initial premium has been paid; and (3) all medical exams or tests required by National Western are completed; and (4) as of the date of this Agreement, the proposed insured must be insurable at standard rates for the type and amount of insurance applied for.

Temporary Insurance will end on the earliest of the following dates: (1) the date insurance begins under the policy applied for; (2) the date this application is cancelled or declined; or (3) 60 days have passed since the date of this application.

*Leave receipt with applicant if money is collected. If no funds are collected indicate none and submit this page along with application.

DETACH AND LEAVE WITH APPLICANT
(DO NOT SEND TO NATIONAL WESTERN)

Date_____

NOTICE UNDER THE FAIR CREDIT REPORTING ACT. This is to inform you that, as part of our procedure for processing your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. None of the information described in this paragraph will be used to establish, or aid in establishing, the proposed insured's sexual orientation. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

MIB DISCLOSURE NOTICE. Information regarding your insurability will be treated as confidential; however, we or our reinsurers may make a brief report thereon to MIB, a not-for-profit membership of insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. We or our reinsurers may also release information to other life or health insurance companies to whom you may (1) apply for life or health insurance, or (2) submit a claim for benefits. Information for consumers about MIB may be obtained on its website at www.mib.com.

NOTICE OF INFORMATION PRACTICES. Residents of Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Montana, New Mexico, Nevada, New Jersey, North Carolina, Ohio, Oregon and Virginia must be given and sign an Authorization to Obtain and Disclose Information and Notice of Information Practices [SU-6412(current version)]. New Mexico residents are to use SU-6412-NM(current version).

SERFF Tracking #:	*NAWS-128834232*	***State Tracking #:***		***Company Tracking #:***	*01-9063-12 APPLICATION FOR INDIVIDUAL LI...*

State:	*Arkansas*	***Filing Company:***	*National Western Life Insurance Company*
TOI/Sub-TOI:	*L09I Individual Life - Flexible Premium Adjustable Life/L09I.001 Single Life*		
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Project Name/Number:	*01-9063-12 APPLICATION FOR INDIVIDUAL LIFE INSURANCE/01-9063-12 APPLICATION FOR INDIVIDUAL LIFE INSURANCE*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
01-9063-12 Officer Flesch Cert.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	COVER LETTER		
Comments:			
Attachment(s):			
AR 01-9063-12 Cover Letter.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	STATEMENT OF VARIABILITY		
Comments:			
Attachment(s):			
01-9063-12 Statement of Variability.pdf			

NATIONAL WESTERN LIFE INSURANCE COMPANY

FLESCH READING EASE TEST SCORE CERTIFICATE
Form Number 01-9063-12

I hereby certify the following:

1. The Flesch Reading Ease Test score is as indicated below.

2. The form is printed, except for specifications pages, schedules and tables, in not less than ten point type.

3. The number of words contained in the text is as indicated below.

4. The entire form was analyzed.

Form No.	**Flesch Score**	**Words**
01-9063-12	53	2,636

Paul D. Facey, FSA, MAAA, FCIA, FLMI
Senior Vice President and Chief Actuary

December 31, 2012
Date

NATIONAL®
WESTERN
LIFE INSURANCE COMPANY

January 4, 2013

Arkansas Department of Insurance
Life and Health Compliance
1200 West Third Street
Little Rock, Arkansas 72201-1904

RE: Application for Individual Life Insurance, 01-9063-12
National Western Life Insurance Company, NAIC 66850, FEIN 84-0467208

To whom it may concern:

Please find attached the referenced life insurance application submitted for review and approval. 01-9063-12 is nearly identical to a previously approved application form 01-9063-10 approved for use on March 25, 2010 under SERFF tracking number NAWS-126543268. Following is a list of the differences:

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- Modification of question 3 in Section VIII:
  - FROM: Do you use a walker, wheelchair, motorized scooter or any medical appliance such as oxygen, respirator, or dialysis machine, or have a defibrillator implanted?
  - TO: Do you use any medical appliance such as oxygen, respirator, or dialysis machine, or have a defibrillator implanted?
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- Addition of text under question 16 in Section IX as follows: “Details to yes answers in Section IX”
- Addition of question 17 in Section IX as follows: “Physician’s Name, Address, and Phone Number”
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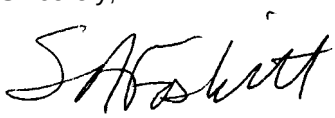
Thank you for your time and consideration in this matter. If you have any questions or need any additional information, please feel free to contact me at (512) 719-1563 or by email at SFoskitt@NationalWesternLife.com.

Sincerely,



Stephanie Foskitt
Contract Compliance Analyst

We reserve the right to change the format of this form without changing any of the language. Printing standards will never be less than those required by your state.

NATIONAL WESTERN LIFE INSURANCE COMPANY

Statement of Variability

Individual Life Application
Form Number 01-9063-12

COMPANY LOGO – at some point in the future, the company may choose to use a different logo.

COMPANY ADDRESS – at some point in the future, the company may choose to move operations to a new address.

MIB NOTICE – at some point in the future the MIB company may choose to revise their required disclosure notice.

Any change or modification to a variable item shall be administered in accordance with the requirements in the Variability of Information section of IIPRC-A-02-I, including any requirements for prior approval of a change or modification.